DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

HERMAN

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02 - 002
2. STATE: Alaska
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.297 - 447.299

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 0.00 (P+I)
b. FFY 2003 $ 0.00 (P+I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Attachment 4.19-A Page 12~~ (P+I)
Attachment 4.19-A Pages ~~15-23~~ 12-24 (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Attachment 4.19-A Page 12~~ (P+I)
Attachment 4.19-A Pages ~~15-24~~ 12-24 (P+I)

10. SUBJECT OF AMENDMENT:
Adds new DSH categories of Mental Health Clinic Assistance DSH and Substance Abuse Treatment Provider DSH; and extends the qualifying year for all providers.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL: Bob Labbe
13. TYPED NAME: Bob Labbe
14. TITLE: Director, Division of Medical Assistance
15. DATE SUBMITTED: March 1, 2002

16. RETURN TO:
Division of Medical Assistance
P.O. Box 110660
Juneau, Alaska 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR - 5 2002
18. DATE APPROVED: MAY 17 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 1 2002
20. SIGNATURE OF REGIONAL OFFICIAL: /S/
21. TYPED NAME: Bunnie Butterfield
22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID

23. REMARKS:
P+I changes authorized by the State on 4/18/02.

FORM HCFA-179 (07-92)

Instructions on Back

XI Hospitals Serving A Disproportionate Share of Low Income Patients:

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for qualifying hospitals. Hospitals serving a disproportionate number of patients with special needs will receive a payment adjustment based on the following criteria and methods:

To be eligible for a disproportionate share payment a hospital must:

(1) be an acute care hospital, a specialty hospital, or a psychiatric hospital;

(2) meet the obstetrical staffing requirements of 42 U.S.C. 1396r-4(d), and must provide the names and Medicaid provider numbers of at least two obstetricians who meet the requirements of that section, unless it qualifies for the exception set out in 42 U.S.C. 1396r-4(d)(2); and

(3) have a minimum Medicaid utilization rate of not less than one percent for the qualifying year.

Disproportionate Share Hospital (DSH) payments are subject to several requirements, including federal allocation of DSH funds, legislative appropriation of DSH funds, facility specific limit on receipt of DSH funds, and other requirements identified in the State Plan. The State intends to make DSH payments to facilities that satisfy such requirements in response to their respective service to low-income patients with special needs. To accomplish this goal, it is understood in this State Plan, that the State intends to adjust DSH payments to ensure that the costs incurred on behalf of Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment from the federal government.

(1) DSH Payment Classifications. An eligible hospital may receive a DSH payment under one or more of the following classifications:

- Medicaid Inpatient Utilization Disproportionate Share Hospital;
- Low Income Disproportionate Share Hospital;
- Single Point of Entry Psychiatric Disproportionate Share Hospital;
- Designated Evaluation and Treatment Disproportionate Share Hospital;
- Institution for Mental Disease Disproportionate Share Hospital;
- Children's Medical Care Disproportionate Share Hospital;
- Institutional Community Health Care Disproportionate Share Hospital;
- Rural Hospital Clinic Assistance Disproportionate Share Hospital;
- Mental Health Clinic Assistance Disproportionate Share Hospital;
- Substance Abuse Treatment Provider Disproportionate Share Hospital; and
- Remainder of Government Allocation Disproportionate Share Hospital.

Mental Health Clinic Assistance and Substance Abuse Treatment Provider DSH are agreements to provide services through freestanding clinics and their costs are not included in the hospital facility specific limit for DSH payments.

(a) Medicaid Inpatient Utilization Disproportionate Share Hospital (MIU DSH)
A hospital eligible for a DSH payment may qualify for a MIU DSH payment adjustment if the hospital has a state Medicaid inpatient utilization rate at least one standard deviation above the mean of state Medicaid inpatient utilization rates for all hospitals in the state; the department will make a pediatric outlier payment adjustment, as necessary, in the manner described under section 2(b), MIU DSH and LI DSH Payments.

The state Medicaid inpatient rate is a fraction, expressed as a percentage, of which the numerator is the hospital's number of Medicaid-eligible inpatient days in this state for the hospital's qualifying year and the denominator is the total number of the hospital's inpatient days including Medicaid managed care days for its qualifying year; and the mean of Medicaid inpatient utilization rates for all hospitals in the state is the fraction, expressed as a percentage, of which the numerator is the total number of Medicaid-eligible inpatient days including Medicaid managed care days for all hospitals in this state for their qualifying year and the denominator is the total number of inpatient days for all hospitals in this state for their qualifying year.

(b) Low Income Disproportionate Share Hospital (LI DSH)
A hospital eligible for a DSH payment may qualify for a LI DSH payment adjustment if the hospital has a low-income utilization rate exceeding 25 percent; the department will make a pediatric outlier payment adjustment, as necessary, in the manner described under section 2(b), MIU DSH and LI DSH Payments.

The low-income utilization rate is calculated as the sum of: a) the fraction, expressed as a percentage, of which the numerator is the sum of the total Medicaid hospital revenue paid to the qualifying hospital for patient services provided to Medicaid-eligible patients including Medicaid managed care patients in this state in the hospital's qualifying year and the amount of cash subsidies received directly from the state or from local governments for patient services provided in this state in the hospital's qualifying year, and the denominator is the total amount of hospital revenue for services, including the amount of cash subsidies specified in this subparagraph for that hospital's qualifying year; and b) the fraction, expressed as a percentage, of which the numerator is the total amount of the qualifying hospital's charges for inpatient hospital services attributable to charity care for the hospital's qualifying year, less the portion of any cash subsidies received directly from the state or from local governments for inpatient hospital services, and the denominator is the total amount of the hospital's charges

for inpatient services for the hospital's qualifying year; for a state-owned qualifying hospital that does not have a charge structure, the hospital's charges for charity care are equal to the cash subsidies received by the hospital from the state or from local governments.

out-of-state hospitals providing inpatient services to Alaska Medicaid recipients and who have a disproportionate share of Medicaid patients may request to receive a payment adjustment relative to the methods and standards in (1)(a) and (1)(b) above. If an out-of-state hospital does request a DSH adjustment, they must supply all necessary data in order for the State to complete the calculations.

(c) Single Point of Entry Psychiatric Disproportionate Share Hospital (SPEP DSH)
A hospital other than an IMD that is eligible for a DSH payment may qualify for a SPEP DSH payment adjustment if the hospital enters into a SPEP DSH agreement with the department under which it agrees to report the number of SPEP encounters for use in determining the appropriate distribution of SPEP DSH funds among all hospitals that qualify for an SPEP DSH payment.

(d) Designated Evaluation and Treatment Disproportionate Share Hospital (DET DSH)
A hospital other than an IMD that is eligible for a DSH payment may qualify for a DET DSH payment adjustment if is designated as an evaluation and treatment facility as required by department regulations (7 AAC 72) and it enters into an agreement with the department under which it agrees to report the number of DET encounters for use in determining the appropriate distribution of DET DSH funds among all hospitals that qualify for an DET DSH payment.

(e) Institution for Mental Disease Disproportionate Share Hospital (IMD DSH)
A psychiatric hospital eligible for a DSH payment may qualify for a IMD DSH payment adjustment if the hospital is designated to receive involuntary commitments under state law. The total amount of funds available for IMD DSH payments is limited by the appropriation of the legislature and the federal percentage of federal DSH funding allowed for IMD payments.

(f) Children's Medical Care Disproportionate Share Hospital (CMC DSH)
A hospital other than an IMD that is eligible for a DSH payment may qualify for a CMC DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of CMC encounters for use in determining the appropriate distribution of CMC DSH funds among all hospitals that qualify for an CMC DSH payment.

(g) Institutional Community Health Care Disproportionate Share Hospital (ICHC DSH)
A hospital other than an IMD that is eligible for a DSH payment may qualify for a ICHC DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of ICHC encounters for use in determining the appropriate distribution of ICHC DSH funds among all hospitals that qualify for an ICHC DSH payment.

(h) Rural Hospital Clinic Assistance Disproportionate Share Hospital (RHCA DSH)
A hospital other than an IMD that is eligible for a DSH payment may qualify for a RHCA DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of RHCA encounters for use in determining the appropriate distribution of RHCA DSH funds among all hospitals that qualify for an RHCA DSH payment.

(i) Mental Health Clinic Assistance Disproportionate Share Hospital (MHCA DSH)
A hospital other than an IMD that is eligible for a DSH payment may qualify for a MHCA DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of MHCA encounters for use in determining the appropriate distribution of MHCA DSH funds among all hospitals that qualify for an MHCA DSH payment.

(J) Substance Abuse Treatment Provider Disproportionate Share Hospital (SATP)
A hospital other than an IMD that is eligible for a DSH payment may qualify for a SATP DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of SATP encounters for use in determining the appropriate distribution of SATP DSH funds among all hospitals that qualify for an SATP DSH payment.

(k) Remainder of Government Allocation Disproportionate Share Hospital (ROGA DSH)
A hospital other than an IMD that is eligible for a DSH payment may qualify for a ROGA DSH payment adjustment if it enters into an agreement with the department for a ROGA DSH payment and has sufficient FSL to receive a ROGA DSH payment after all other DSH payments to the hospital for the qualifying year are determined.

(2) Distribution of DSH Payments. DSH payments will be distributed to qualified hospitals according to the following methods.

(a) IMD DSH. Each disproportionate share payment for the IMD DSH classification will be calculated based on the qualifying hospital's Medicaid inpatient days, divided by the sum of the Medicaid inpatient days of all qualifying

IMD DSHs in the qualifying year; the resulting percentage will be multiplied by the amount of the allocation of DSH funds applicable to the IMD DSH classification. Payments will be subject to the hospital's FSL, the federal IMD disproportionate share cap in effect for the federal fiscal year in which payments are made, and the amount of appropriations from the legislature as allocated by the department.

(b) MIU DSH and LI DSH Payments. Each qualifying hospital within the MIU DSH classification and each qualifying hospital within the LI DSH classification will receive a minimum payment of $10,000 per payment year and per classification, subject to the hospital's FSL, the federal IMD disproportionate share cap in effect for the federal fiscal year in which payments are made, and the amount of appropriations from the legislature as allocated by the department.

Each disproportionate share payment for the MIU DSH classification will be calculated based on the qualifying hospital's SDM, divided by the sum of the SDMs of all qualifying MIU DSHs in the qualifying year; the resulting percentage will be multiplied by the amount of the allocation of DSH funds applicable to the MIU DSH classification. "SDM" means the amount over a Medicaid inpatient utilization rate at least one standard deviation above the mean of state Medicaid inpatient utilization rates for all hospitals in the state.

Each disproportionate share payment for the LI DSH classification will be calculated based on the qualifying hospital's LUR, divided by the sum of the LURs of all qualifying LI DSHs in the qualifying year; the resulting percentage will be multiplied by the amount of the allocation of DSH funds applicable to the LI DSH classification. "LUR" means the amount over a low-income utilization rate exceeding 25 percent.

Hospitals that qualify for an MIU DSH or for an LI DSH payment will receive a pediatric outlier payment adjustment in the disproportionate share payment if the hospital provides inpatient services not excluded under state Medicaid regulations to a Medicaid patient who is under age six at the time of admission and that involve exceptionally long stays per admission that are 150 percent or more of the length of stay of an average admission for the hospital. The pediatric outlier payment is subject to legislative appropriation and will be divided proportionately among the MIU DSH or LI DSH qualified based upon the number of inpatient days for children under age six who qualify within the respective DSH classification.

(c) Encounter Based Classification Payments. Each disproportionate share payment for the SPEP DSH, DET DSH, CMC DSH, ICHC DSH, RHCA DSH, MHCA DSH and SATP DSH classifications will be calculated within each classification based on the number of encounters to be performed by the

qualifying hospital for that classification, as specified in the agreement required for that classification, divided by the total number of encounters to be performed by all qualifying hospitals within that classification, as specified in the agreements required for that classification; the resulting percentage will be multiplied by the amount of the allocation of DSH funds applicable to that classification.

(d) ROGA Classification Payments. The amount of disproportionate share payments to qualifying hospitals under the ROGA DSH classification will be determined and calculated 1) to not exceed the facility-specific limits established for each hospital; and 2) proportionately to reflect remaining available disproportionate share money after calculation of the payments for other DSH payments classifications.

In determining the amount of a DSH payment the department will allocate the lesser of 1) the amount of those ROGA DSH payments that the qualifying hospital has requested; or 2) a proportionate amount calculated, as a percentage, in which the numerator is the amount of those ROGA DSH payments that the qualifying hospital has requested and the denominator is the sum of all disproportionate share payments to all qualifying hospitals within the ROGA DSH classification.

(3) Payment Limits. The total annual disproportionate share payment for each qualifying hospital is subject to a facility-specific limit (FSL) calculated for the hospital's qualifying year. The FSL is calculated as the cost of services provided to Medicaid patients, less the amount paid to the hospital under the non-DSH provisions of the State Plan, plus the cost of services provided to patients without health insurance or another source of third party payments that applied to services rendered during the qualifying year, less any payments made by those patients without insurance or another source of third party payment for those services; the hospital's cost of services for this calculation is the total hospital allowable costs as defined in the State Plan divided by the hospital's total adjusted inpatient days; this result is multiplied by the total of the hospital's adjusted inpatient days not covered by insurance or third party payment and Medicaid adjusted inpatient days; the cost of services includes the cost of excluded services under an insurance policy; the cost of services does not include amounts that were not reimbursed to the hospital by the patient's health insurance or other source of third party payments because of per diem maximums, coverage limitations, or unpaid patient co-payments or deductibles; for purposes of this paragraph, third party payments do not include state payments to hospitals paid by the department's programs for General Relief Medical Assistance (7 AAC 47) or Chronic and Acute Medical Assistance (7 AAC 48.500 - 7 AAC 48.900).

Inpatient days not covered by insurance is determined from a log submitted by the hospital and reviewed and accepted by the department before a DSH payment is

made. The submitted log must include in sufficient detail for the department to verify uninsured care: charges, admissions, patient days, any payments made by the patient for the services offered, payments made on behalf of the patient by a third party for the services offered, and dates of service. A hospital must bill insurance and other third party sources whenever possible. A log entry for a person who has insurance that records zero payment made by the insurance will be accepted as demonstrating no insurance for the services offered, however, such a log entry will be reduced by $1,000 to ensure that non-payment as a result of an insurance policy deductible is excluded from the log. If the hospital attaches an explanation of benefits or other documentation from the insurance company that demonstrates the services offered are excluded from coverage under the patient's insurance policy, the entire amount of that log entry will be accepted, subject to the other requirements in this paragraph, when determining the amount of uninsured care.

A disproportionate share payment is not subject to the limitations of 100% of charges.

(4) Hospital Notification and Reconsideration. The department will notify eligible hospitals each year of its allocation of available DSH funds to DSH classifications and will and provide an opportunity for eligible hospitals to participate in each DSH classification. Eligible hospitals that choose to participate will give notice to the department in writing. The department's determination of the participation by an eligible hospital will be contingent upon its submission of a certified log of uninsured care for the qualifying year and the department's determination of the sufficiency of the hospital's FSL to receive DSH payments.

On or before the qualification date, the department will send to each hospital a list of the qualifying hospitals and the amount of the payments for the upcoming payment year, except that for payment year 2002, the department will send that list on or before December 3, 2001. The department's determination will be the department's final administrative action, unless a request for reconsideration is filed as required within department regulations.

(5) Monitoring and Recouping. The department will monitor DSH payments quarterly, in quarters in which a DSH payment is made. Each quarter DMA will receive a report showing the amounts paid for each DSH payment. Expenditures under that report will be reviewed to assure that FSLs have not been exceeded for the qualifying year of hospitals that receive a DSH payment. If a hospital reaches its FSL, payments will be stopped. If a hospital exceeds it's FSL the department will recoup the excess part of DSH payments in the following order of payments: ROGA DSH, SATP DSH, MHCA DSH, RHCA DSH, ICHC DSH, CMC DSH, DET DSH, SPEP DSH, LI DSH, MUI DSH, IMD DSH. For example, if a hospital were receiving payments from all DSH programs, the over payment

adjustment would be made in ROGA DSH to the extent possible before adjusting RHCA DSH payments. Similarly, if the DSH state-wide allotment is exceeded appropriate adjustments will be made in the payment order shown above.

The State will recalculate and reallocate the disproportionate share eligibility and payments for all hospitals and will recoup payments from all hospitals if the disproportionate share eligibility and payment for any hospital must be recalculated as a result of a final commissioner's decision in an administrative appeal or of a court decision that would cause the total disproportionate share payments to exceed the federal allotment and/or the IMD cap for the federal fiscal year in which the payment rate was in effect.

The total disproportionate share payments to all hospitals in the aggregate will be limited to the Federal disproportionate share cap established for the State of Alaska. A comparison of the Federal cap to the State's estimated total disproportionate share payments for the federal fiscal year will occur before any payments are distributed to qualifying hospitals.

(6) Definitions.

(a) "encounter" means a unit of service, visit, or face-to-face contact that is a covered service under an agreement with the department as required under (d)(3), (d)(4), (d)(6), (d)(7), (d)(8), or (d)(9) of this section.

(b) "institution for mental disease" or "IMD" means a facility of more than 16 beds that is

primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services; whether an institution is an institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not the facility is licensed as such.

(c) "inpatient days" means patient days at licensed hospitals that are calculated

(1) to include patient days related to a hospitalization for acute treatment of the following:

(A) injured, disabled, or sick patients;

(B) substance abuse patients who are hospitalized for substance abuse detoxification;

(C) patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(D) patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness;

(E) newborn infants in hospital nurseries; and

(2) not to include patient days related to the treatment of patients

(A) at licensed nursing facilities;

(B) in a residential treatment bed;

(C) on a leave of absence from a hospital beginning with the day the patient begins a leave of absence;

(D) who are in a hospital for observation to determine the need for inpatient admission; or

(E) who receive services at a hospital during the day but are not housed there at midnight.

(d) "Medicaid-eligible inpatient days" means patient days at licensed hospitals that are calculated

(1) to include Medicaid covered and Medicaid non-covered days related to a hospitalization for acute treatment of the following:

(A) injured, disabled, or sick patients;

(B) substance abuse patients who are hospitalized for substance abuse detoxification;

(C) patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(D) patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness;

(E) newborn infants in hospital nurseries; and

(2) not to include Medicaid covered and Medicaid non-covered patient days related to the treatment of patients

(A) at licensed nursing facilities;

(B) in a residential treatment bed;

(C) on a leave of absence from a hospital beginning with the day the patient begins a leave of absence;

(D) who are in a hospital for observation to determine the need for inpatient admission; or

(E) who receive services at a hospital during the day but are not housed there at midnight.

(e) "payment year" means the state fiscal year.

(f) "qualifying hospital" means a hospital that qualifies for one or more DSH payments under this section.

(g) "qualifying year" means the hospital's most recent fiscal year ending 31 to 37 months before the state fiscal year in which the disproportionate share payment is made.

XII. Exceptional Relief to Rate Setting:

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the deputy commissioner of the department for exceptional relief from the rate setting methodology. This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;

2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;

3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;

4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. an analysis of community needs for the service on which the exception request is based;

7. a detailed analysis of the options of the facility if the exception is denied;

8. a plan for future action to respond to the problem; and

9. any other information requested by the deputy commissioner to evaluate the request.

The deputy commissioner may request recommendations from the Commission on a facility's application for exceptional relief. The deputy commissioner may increase the rate, by all or part of the facility's request if the deputy commissioner finds by clear and convincing evidence that the rate established under section IV. and V. of Attachment

4.19-A does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the deputy commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;

2. the assessment of continued need for this facility's services in the community;

3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;

4. the recommendations, if any, from the Commission;

5. the availability of other resources available to the facility to respond to the crisis;

6. whether the relief should have been obtained under the existing rate methodology;

7. other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

The deputy commissioner will impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. the facility sharing the cost of the rate exception granted;

2. the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;

3. the facility providing documentation as specified of the continued need for the exception; or

4. a maximum amount of exceptional relief to be granted to the facility under this section.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the deputy

commissioner concerning exceptional relief may request an administrative hearing to the commissioner of the department.

XIII. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

XIV. Proportionate Share Incentive Payments for Public Hospitals.

1. The department recognizes that many public hospitals provide basic support for community and regional health care to clients who would otherwise be unable to readily access needed inpatient hospital service. To ensure continued access, proportionate share incentive payments (Hospital Pro-Share payments) are provided to in-State public hospitals. At least annually the department will advise all such hospitals to formally request participation in the Hospital Pro-Share payment program.

2. A public hospital is one that is owned by a government entity.

3. Hospital Pro-Share payments shall be paid at least annually during each Federal Fiscal Year based on legislatively approved appropriations and the State's determination of the amount of funding available for the Hospital Pro-Share payments. The State recognizes that occupancy is the key measure in determining the payment for each participating hospital. Specifically, a hospital with a low occupancy level tends to be more fiscally vulnerable compared to a hospital with a high occupancy level. Each participating hospital will be assigned an occupancy weight as follows:

Occupancy Level	Occupancy Weight
40 percent or more	1.00
30 – 39 percent	1.05
20 – 29 percent	1.10
10 – 19 percent	1.15
less than 10 percent	1.20

The occupancy level used to determine a hospital's occupancy weight will be the percent that results from dividing the total number of patient days by the total number of available bed days disclosed in the Medicare cost report for the hospital's fiscal year ending 24 months before the payment.

A payment per occupancy weight is determined by dividing total available funds by the sum of the occupancy weights assigned to each participating hospital. The resulting amount is then applied to the participating hospital's assigned occupancy weight. Hospital Pro-Share payments will be subject to the Medicare upper limit requirement at

42 CFR 447.272 and will be made only after the State's analysis assures that the aggregate Medicare upper limit will not be exceeded.

4. Hospital Pro-Share payments will not be subject to settlement (payment at the lower of costs or rate), or to state law governing payment rates AS 47.07.070 or regulations in 7 AAC 43.670 – 7 AAC 43.709.